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Title

Islamophobia in the National Health Service: An Ethnography of Institutional Racism in PREVENT's
Counter-Radicalisation Policy

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Abstract

In 2015, the UK government made its counter-radicalisation policy a statutory duty for all National Health Service (NHS) staff. Staff are now tasked to identify and report individuals they suspect may be vulnerable to radicalisation. Prevent training employs a combination of psychological and ideological frames to convey the meaning of radicalisation to healthcare staff, but studies have shown that the threat of terrorism is racialised as well. The guiding question of our ethnography is: how is counter-radicalisation training understood and practiced by healthcare professionals? A frame analysis draws upon two years of ethnographic fieldwork, which includes participant observation in Prevent training and NHS staff interviews. This paper demonstrates how Prevent engages in performative colorblindness: the active recognition and dismissal of the race frame which associates racialised Muslims with the threat of terrorism. It concludes with a discussion of institutional racism in the NHS: how racialised policies like Prevent impact the minutia of clinical interactions; how the pretense of a 'post-racial' society obscures institutional racism; how psychologisation is integral to the performance of colorblindness; and why it is difficult to address the racism associated with colorblind policies which purport to address the threat of the Far-Right.

Keywords

Prevent; Islamophobia; institutional racism; British Muslims; NHS; colorblindness; counter-terrorism; UK

Word count: 8368 words

1. Introduction: An Ethnography of Counter-terrorism in Healthcare

The UK government identifies terrorism as one of the highest priority risks to the nation (HM Government, 2018). To thwart the uncertain threat, the UK implemented a national counter-radicalisation policy called Prevent, whereby radicalisation relates to the process by which individuals develop an intent to carry out political violence. Prevent sits apart from its three sister-strands, Pursue, Protect and Prepare, in the UK's national counter-terrorism strategy, CONTEST. While the latter deal with the management of a terrorist attack, Prevent seeks to avert individuals from endorsing, joining or becoming terrorists *in the future*. The UK is the only country in the Global North to implement counter-radicalisation as a *duty* upon public bodies such as the National Health Service (NHS), who in turn must demonstrate their compliance with the Prevent policy (HM Government, 2015). Thus, since 2015, the government officially designates healthcare a 'pre-criminal space' (Goldberg et al., 2017). NHS staff must now undergo mandatory counter-radicalisation training to identify and report individuals they suspect may be vulnerable to radicalisation.

The Prevent policy has been controversial since its official launch in 2007 (Kundnani, 2009). Despite the policy's disparate iterations over the years, one concern has remained consistent: its racism (Open Society Justice Initiative, 2016). This concern has been raised by unions, NGOs, religious organisations, over 140 academics and international rights groups such as the United Nations (Younis and Jadhav, 2019). In spite of this, there is little research exploring Prevent's impact on healthcare practices, though over 830,000 NHS staff have received Basic Prevent Awareness training and over 470,000 have attended advanced training (UK Parliament, 2018). Our fieldwork set out to explore how Prevent's counter-radicalisation duty has entered clinical logic. In doing so, it traces one of the mechanisms by which racism operates in healthcare: colorblindness. By employing Goffman's use of 'frames', this paper will

explore the impact of the UK government's colorblind introduction of 'radicalisation' into healthcare settings.

2. Counter-Terrorism, Race and Healthcare

The following summarises the Prevent procedure at the time of writing: if a staff member deems a patient vulnerable to radicalisation, they inform their NHS safeguarding lead who gauges the need for a Prevent referral. If a referral is made, the patient's file is sent to the police who assess and cross-examine the patient's information with their local database to ascertain if the patient was under investigation. At this point, the patient's details are stored in a special police database for seven years, even if the referral is closed (NHS England, 2017). If the patient is not deemed a threat but still considered vulnerable to radicalisation, the police may forward the file to Channel. Every borough has a Channel panel, composed of various professionals and local community members who devise an intervention strategy which may include mental health services, ideological reprogramming, housing, etc. The patient is then informed of Channel's decision and can *choose* to reject the proposed intervention, although failure to comply may lead to a police investigation (Cobain, 2018).

Prevent's counter-radicalisation framework is based on the Extremism Risk Guidance 22+ (ERG22+), whose development academics have criticized for lack of transparency and deficiency in scientific rigour (Scarcella et al., 2016). As there is insufficient evidence to associate an individual's potential for political violence with health status, the government justifies counter-terrorism's integration into the NHS based on the number of patients who pass through the institution (HM Government, 2011, p. 85). Prevent's implementation in healthcare thus belongs to a logic of big data and surveillance superimposed upon standard risk assessments—what Health-Kelly (2017a) calls algorithmic autoimmunity.

In order to account for the racial element in the delivery of counter-radicalisation, we employ Goffman's (1986) frame analysis. Goffman argues that social interactions are experienced through

frames which organise their meaning along “schemata of interpretations”. These schema allow individuals to understand events and interactions as they occur. The importance of framing is significant: it makes an interaction both comprehensible and meaningful within a shared, predefined logic. At the same time, frames provide the boundaries to which meaning can be made—the boundaries of pre-shared logic. Frames thus operate by making certain interpretations of an event prominent, while obfuscating others. For example, the concept of frames is used to explain how television imagery can influence people to incorporate particular logics of how to interpret world events (Coltrane and Messineo, 2000, p. 364). This is significant as prejudice is often analysed as a cognitive phenomenon but rarely as a system of meaning (Skrentny, 2008, p. 65).

There is emerging research highlighting the importance of *race frames* when discussing how race is understood in society (Warikoo and de Novais, 2015). In this paper, ‘race’ is fundamentally related to power. This power is made visible within a racial hierarchy whereby Whiteness is privileged as the norm (Bhattacharyya et al., 2016, p. 2), and non-white groups are racialised according to dominant social conflicts in society (Omi and Winant, 2014). Racialisation here designates the process whereby social conflicts, such as the War on Terror, reify the signifiers associated with particular bodies and behaviours, such as the beard on Muslims. As all social relations are subject to power, so too is racial hierarchy embedded within the logic of all social interactions—this is the race frame. There is an extensive body of literature documenting how the threat of terrorism is associated with Muslim bodies in public consciousness (Sharma and Nijjar, 2018). We relate here to “Muslim bodies” unambiguously; actual religiosity is not the qualifying factor for this association with terrorism (Sian, 2017). The race frame thus explains how non-Muslims (e.g. Sikhs) experience discrimination for their perceived association with Islam (Friedersdorf, 2010).

Studies examining racial inequalities in healthcare predominantly focus on racial discrimination and attend less to the process of racialisation underlying structural inequalities (Hicken et al., 2018, p. 11).

The emerging concept of ‘clinical mindlines’ is significant in this regard; it explains how clinical logic reflects political and ethical dimensions of public consciousness (Wieringa and Greenhalgh, 2015, p. 8). In other words, healthcare settings embody the race frames found in society. For example, a recent review of the Mental Health Act (2018) has found that Black individuals are more likely to be seen as aggressive – therefore justifying stronger forms of coercion – than their White counterparts when sectioned. Unsurprisingly, Muslim patients and staff also experience increasing discrimination in UK healthcare settings (Samari et al., 2018).

Little is known how race frames operate in healthcare settings, or indeed how the racialisation of Muslim patients impacts healthcare access and interventions (Laird et al., 2007). While the race frame’s association with radicalisation raises concerns with the enterprise of counter-radicalisation, the Prevent policy no longer *exclusively* focuses on British Muslims since 2011 (Home Office, 2011). Thus, a point must be made on colorblindness. Colorblindness is the position whereby race is dismissed or minimized in social interactions, either by rejecting the possibility of white privilege or by diminishing the importance of racism in social structures (Frankenberg, 1993). Both are processes which sustain racist structures, while protecting those in power from the charge of racism (Alexander, 2012, p. 203). The purpose of this paper is not to make a statement about how radicalisation *ought* to be framed but to show how, irrespective of its framing, NHS staff will inevitably draw upon a race frame in determining *who* a radical is.

Ethnography of Counter-Terrorism in Healthcare: Navigating a Sensitive Field

This paper is based on an ethnography carried out in London between May 2017 and January 2019. Ethical approval for this research was granted by University College London’s Research Ethics Committee (Reference number: 10899/001). Fieldwork consisted of policy analysis, participant observation in Prevent training sessions, as well as formal interviews with 17 NHS staff (see Table 1 in

the Appendix; details withheld and generalized to ensure anonymity). All participants were recruited via snowballing through recruitment flyers shared via public and several closed General Practitioner professional listservs networks. Snowballing method is a favoured method in health practitioner research (Carey et al., 1996) given that healthcare settings rely heavily on trust (Gabbay and le May, 2004). As counter-terrorism is a sensitive and moralising subject (Younis and Jadhav, 2019), snowballing has the advantage of being able to rely on informal networks of trust. At the same time, snowballing's disadvantage is that it potentially draws from a particular set of participant characteristics. In our cohort, it appeared our participants either held a critical outlook towards State-driven or Eurocentric healthcare models (and were thus sensitive to racialisation) or belonged to a racialised minority group themselves.

Due to the sensitivity of the subject of counter-terrorism, as well as the difficulties in accessing the field, none of the fieldwork took place on NHS premises. Our cohort consisted of NHS staff who were critical of the PREVENT policy. This was not intended, but we soon realized the moral dimension of counter-terrorism and the need to fulfill the statutory duty of Prevent made our subject difficult to discuss critically¹. That being said, not all participants were equally critical, and those who were did not all share the same reasons why. Indeed, some participants still held an indecisive or positive outlook towards the Prevent policy though they attested to its potential for racial discrimination².

Throughout recruitment, NHS professionals admitted they would rather avoid politically sensitive subjects. As time progressed however, the primary author became increasingly known as critical of Prevent. This is important as staff admitted they were unsure of the researcher's intentions due to Prevent's sensitivity but admitted feeling more comfortable knowing the primary author's positioning. Besides attending formal events discussing the role of counter-terrorism and race in the NHS, the primary author's critical positioning opened additional venues of participant interactions in informal

settings, such as WhatsApp/email discussions and meetings with anti-racist advocacy groups and human rights organisations interested in the Prevent policy.

Furthermore, the primary author attended Prevent training: a half-day Prevent workshop; a two-hour NHS-specific Prevent safeguarding workshop; and several online Prevent training sessions for mental health professionals. All training was free, open to the public and delivered and/or approved by the Home Office. The primary author's role as a researcher was only divulged when asked, though they always stated it in the training registration form. Given the lecture style of the training sessions, participant observation was predominately an exercise in observing and taking field notes, save for instances involving group activities. All three training modules issued Prevent certificates upon completion. Of note is that the half-day workshop included educators although the main themes of Prevent training are consistent across public bodies.

This ethnography was participatory: fieldwork developed according to the input and advice of key stakeholders in both healthcare and Muslim communities. Over time the research focus changed as race emerged as central in the logic of Prevent referrals. What began as an exploration of counter-radicalisation in healthcare developed into a study of how racialised policies are constructed and maintained within healthcare logic. Fieldnotes and interviews were examined using thematic content analysis to discover patterns within the observations (Braun and Clarke, 2006). We employed a contextualized approach to our fieldwork, valuing both explicit meanings found in policy documents, Prevent training statements and participant narratives, as well as the context which formulated the boundaries in which those meaning can be constructed. Our analysis primarily emphasized themes relating to race. Two researchers found a high degree of consistency in extrapolated themes. Themes were then categorized and linked to the overall research objectives. All names are pseudonyms and key details have been changed to ensure anonymity and confidentiality.

3. Prevent Training: Obscuring race through clinical intuition

The following section will address two themes in relation to the maintenance of colorblindness: the reliance on intuition and the explicit dismissal of the race frame.

Elusive risk factors and clinical intuition

A large portion of the half-day workshop was dedicated to raising awareness and highlighting the responsibility of the attendees in helping to prevent terrorism. As was observed by Coppock and McGovern (2014, p. 248), we noted a ubiquitous use of ‘psychology talk’ reinforced within a paradigm of ‘clinical intuition’ throughout Prevent training:

When it came to the subject of vulnerability, the trainer acknowledged the complexity of radicalisation but then iterated a list of psychologising factors nonetheless, such as conditions of ‘identity loss’ and ‘desire for belonging’. I remained silent throughout the workshop, preferring not to interrupt the trainer’s script or influence participant responses. The trainer continued to make the following comment while elaborating on emotional signs of vulnerability: “It could be an adolescent who loses confidence, but it could also be an adolescent who gains confidence.” Knowing well that fluctuating confidence is a hallmark of adolescence, I decided to engage with the trainer: “I’m sorry, I don’t think I understand. What do you mean by an *adolescent* who either *gains* or *loses confidence*?” A chorus of murmurs sounded the room as others agreed and made their confusion known. The trainer nodded and smiled: “Yes, I understand this may be confusing”. Ultimately, she added, it all comes down to this: we have to “trust our gut feeling that something is not right” and “refer every minuscule of concern”. That was the point of this exercise, she concluded. (first author, field notes)

Prevent training strongly emphasizes the centrality of intuition, an observation previously made in healthcare (Heath-Kelly and Strausz, 2018) and education (Coppock and McGovern, 2014). This emphasis on intuition can be attributed to several factors. First, there is already precedence in healthcare to develop clinical acumen and rely on professional judgment in the face of uncertainty and complexity (Riaz and Krasuski, 2017). Prevent's insistence on intuition is thus framed as a logical extension of clinical acumen for staff to 'make sense' of their counter-radicalisation duty. Second, the evidence-base underlying Prevent's risk framework is clandestine, and what is known exposes glaring deficiencies (Sarma, 2017, p. 281; Scarcella et al., 2016, p. 15). Third, we contend this insistence on intuition conveniently bypasses the need of any specific criminological profiles, which facilitates a wider frame of psychologisation.

Indeed, Prevent trainers are specifically instructed to associate all emotional and behavioural signs with vulnerability, as outlined explicitly in the Prevent trainer script (HM Government, 2016, p. 14):

Pick a circumstantial vulnerability from the case study you have played and relate this to an emotion or feeling (in that example it might be depression/low self-esteem/feeling of worthlessness). *Try and steer the responses to emotions and feelings – these are after all what are truly exploited by a radicaliser.* (emphasis added)

In another script, one written for the NHS, the Prevent trainer is encouraged to state the following:

Everyone is different, so an individual who is susceptible to radicalisation may have *one, all or none of the factors* highlighted in this exercise. Indeed, many of the factors we've listed can indicate issues that have nothing to do with radicalisation. (emphasis added)

While relationship between mental health and political violence ranges from dubious to non-existent (Ahonen et al., 2017), the Prevent policy and training insists upon the psychology frame nonetheless. This is best exemplified the case below.

Early in my fieldwork, it was revealed to me in confidence that Prevent has embedded its counter-radicalisation framework within the standard Comprehensive Risk Assessment tool (CRA) for *all patients* visiting a particular Mental Health Trust (MHT; see Figure 1) in London. This fact was then made public by Heath-Kelly and Strausz (2018), who found through Freedom of Information requests that—unbeknownst to the public—this development has taken place within at least four MHTs across the UK. A screen within the CRA now shows a list of psychologizing risk factors, including anger, susceptibility/influence and mental health (taken from the ERG22+, explained above). The totalising overlap between the space—a mental health institution—and counter-radicalisation affirms the government’s objective to psychologize the threat of terrorism.

Radicalisation or Exploitation No historical risk recorded on ePJS

Current or Historical Risk of Radicalisation or Exploitation? ☒ Yes ☐ No ☐ Not Sure

History of related Risk Events

Date	Description of Event
No Historical Risk Events recorded on ePJS	

Add Risk Event (20 Maximum)

Risk Factor	Historical	Current	Notes and Comments
Engagement			
Exhibiting feelings of injustice and anger	<input type="checkbox"/>	<input type="checkbox"/>	
Being influenced or controlled by a group/gang	<input type="checkbox"/>	<input type="checkbox"/>	
Appears susceptible to extremist indoctrination	<input type="checkbox"/>	<input type="checkbox"/>	
Concerns about online activity	<input type="checkbox"/>	<input type="checkbox"/>	
Impact of mental health issues	<input type="checkbox"/>	<input type="checkbox"/>	
Intent			
Over-identification with an extremist group or ideology	<input type="checkbox"/>	<input type="checkbox"/>	
Demonstrating Them and Us thinking	<input type="checkbox"/>	<input type="checkbox"/>	
Attitudes that appear at odds with values relating to respect for law, democracy, mutual respect, equality?		<input type="checkbox"/>	
Desire to pursue harmful objectives	<input type="checkbox"/>	<input type="checkbox"/>	
Capability			
Ability to travel easily (e.g. Passport, money available)	<input type="checkbox"/>	<input type="checkbox"/>	
Knowledge, skills and competencies? (e.g. particular expertise/technical training?)	<input type="checkbox"/>	<input type="checkbox"/>	
Access to networks (online or in person), funding, equipment?	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Add Risk Factor (20 Maximum)

Referral

If you have identified 6 of the points as a current risk, then consider a Prevent Referral ☐ Yes ☐ No

Other Risks No historical risk recorded on ePJS

Other Current or Historical Risks? ☐ Yes ☒ No ☐ Not Sure

Trigger Factors

Protective Factors

Summary of Risk

Figure 1. Photo taken from a monitor within a Mental Health Trust in London [picture cropped to maintain anonymity of photographer and setting]. 2019.

The ubiquity of the psychological frame serves an administrative purpose: it allows the government to house counter-radicalisation within safeguarding. However, as Heath-Kelly and Strauzs (2018) found, Prevent sits uneasily among NHS staff as a form of safeguarding. The Care Act (HM Government, 2014) stipulates three necessary pillars to merit an adult safeguarding referral: 1) the adult must be *in need of care and support*, defined as “needs which arise from or are related to a physical or *mental impairment or illness*”; 2) the adult is at risk of abuse; and 3) they are unable to protect themselves from abuse. Thus, it is apparent that the adult safeguarding framework was designed for adults with significant physical and psychological impairments (e.g. individuals with dementia). Are adults perceived to be at risk of radicalisation in need of safeguarding, as stipulated by the Care Act? Prevent training’s insistence on ‘gut feeling’ bypasses the necessity for staff to answer this question themselves. Rather, they are instructed to rely on their intuition and let the safeguarding lead, police and/or Channel make that final decision. Prevent training thus appears to encourage ‘common sense’ as the general guide of intuition. This is where the race frame operates.

Bridging intuition with race: raising and erasing Muslims from radicalisation

The performance of colorblindness in Prevent training was best captured by the inter-changing examples of Muslim and white radicalisation cases. Indeed, the message ‘anyone can be radicalised’ pervades Prevent training. This message is most likely the government’s attempt to assuage those who argue the policy unjustly targets British Muslims (Open Society Justice Initiative, 2016). The spirit of Prevent training however, that ‘race doesn’t matter’, sits unwell with those who believe it does, such as Adam, a racialised Muslim male psychiatrist:

I was surprised but still kind of cautious and guarded: the person delivering the [Prevent] training almost had a disproportionate amount of references to Far-Right extremism and

not to Islamist extremism. I wasn't expecting that. I felt the person was trying to—I wouldn't use the word "deceive"—but it's almost common knowledge that Prevent is treating Muslims as a suspect community. (interview)

For Adam, the trainer's abandonment of Muslim cases was disingenuous given how readily Muslims are associated with terrorism in the public imaginary. But Prevent training does not dismiss the race frame completely. Online Prevent training provides a unique vantage point to experience Prevent training without the mediating subjectivity of the trainer. Beyond oscillating between Muslim and white case examples, the online Prevent module also attempts to dissuade racial prejudice towards Muslims. One of our research participants, Walid, a racialised Muslim male psychiatrist trainee, shared a picture of his training session (Figure 2).

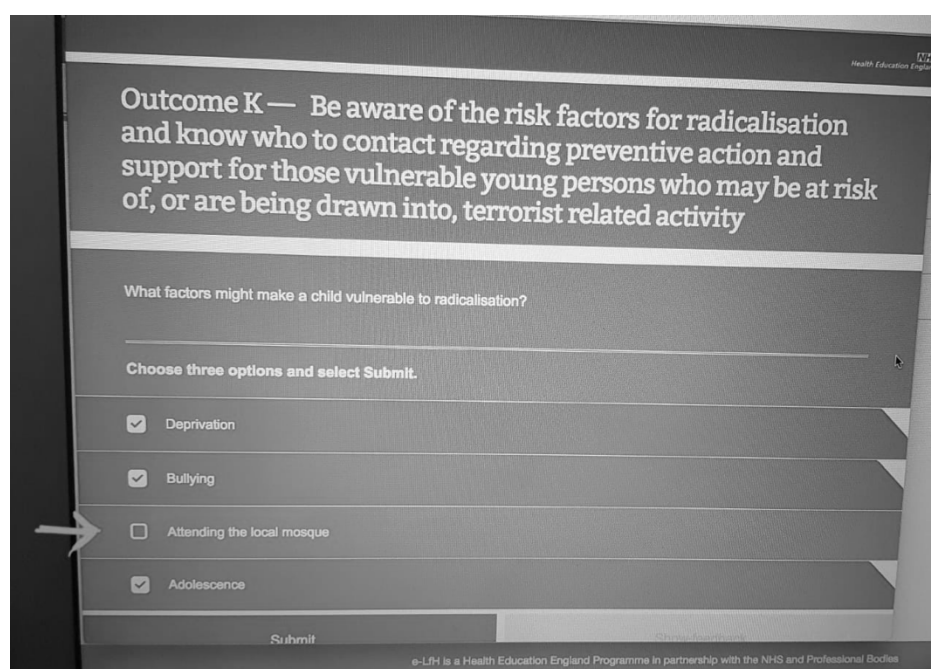


Figure 2. Picture of online Prevent training. The arrow in the photo is the participant's addition. 2018.

Walid admitted he was deeply offended by the sight of "attending the local mosque"³. In discussing the picture, Walid explained the nature of the offense: even in its attempted negation of a stereotype,

the training slide reifies the prejudice that the threat of terrorism may be associated with Islam. In other words, this slide exists *because* the UK government admits there is a possibility staff may perceive Islamic practices (such as mosque attendance) as genuine risk factors associated with radicalisation. Indeed, a recent survey of 5000 Britons found *one-third* would rather not have a mosque built near them (Perraudin, 2019). The purpose of this slide then is performative: by ‘correcting’ a prejudicial stereotype, the government can maintain a blameless position of having addressed the possibility of Islamophobia in Prevent referrals.

We see here the race frame is never completely amiss in training. It is called upon to draw attention to—and immediately dismiss—terrorism’s hegemonic association with Muslims. Prevent training thus takes a pedagogical position by which it presumes the logic of racial prejudice can be ‘trained away’ if made explicit. This pedagogical approach reifies the locus of racial prejudice *within* individual healthcare staff, to the exclusion of social structures which legitimise everyday racial prejudice. Healthcare staff are thus made responsible in correcting their racial prejudices. A racist referral reflects poorly on the healthcare worker—not the policy.

Coincidentally, the primary author became indirectly involved in the development of a novel NHS Prevent training module. In the summer of 2018, a British Muslim NHS staff member was informed of our research and added the primary author to an email correspondence with NHS England. The forwarding email requested a half-dozen Muslim health professionals to review the new Prevent online training module before its launch to ensure Muslims do not feel targeted by its content. The primary author shared their view found in this paper: the issue with Prevent training lies with the hegemonic association of terrorism to Muslims in public consciousness, not the content of any training module. If Prevent training must *actively resist* the race frame pertaining to Muslims by *requesting Muslims to review it*, this only reifies the normative association between Muslims and terrorism.

4. Racism in Practice: Case examples of counter-radicalisation in health settings

Clinical examples reveal how the race frame underlies counter-radicalisation practices. Rather than enumerating a list of racialised incidents—as there already a number of documented examples of Muslims being racially profiled through Prevent in the NHS and elsewhere (see case studies in Open Society Justice Initiative, 2016)—this next section will be devoted to conceptualizing how the race frame operates instead. That being said, we have also documented a number of incidents involving clear racial profiling of Muslim patients during our fieldwork: a non-Muslim refugee from the Middle East was referred for no other known reason but having come from the Middle East; a Muslim was referred for having gone to hajj; a disabled, Muslim adolescent was referred when a nurse found them watching an Arabic YouTube video during a home visit. It is not difficult to observe how the race frame underscored these Prevent referrals. The next three cases will demonstrate how Prevent exposes the race frame underlying clinical interactions in more depth.

Mary

Mary, a white, female GP, is critical of Prevent. During the interview, Mary told me of an encounter with a Muslim patient. This patient, who wore a long beard and an ankle-length garb, admitted contemplating the possibility of homeschooling his children. Mary acknowledged this was an otherwise harmless statement which required elaboration, but suddenly, the Prevent duty interrupted her thought process. Questions unexpectedly arose such as, ‘is he pulling his children out of school because he didn’t want them to integrate?’ Unsure of what to do, and not wanting to go down an uncertain path which may *potentially* lead towards the responsibility of a Prevent referral, Mary decided to withhold any further questions. She thus felt she evaded the accountability associated with the Prevent duty and this was the end of the clinical interruption. (first author, interview)

There are three observations to make in this vignette. First, would the Prevent duty have occurred to Mary if the patient was a White, middle-class woman? It is more likely that the appearance of a racialised Muslim and their interest home schooling—alluding to the moral panic of Muslim (non)integration in British society—immediately evoked the thought of Prevent via its race frame. The *statutory nature* of the Prevent duty gives prejudicial thoughts—now potential risk factors within a pre-criminal space—institutional and clinical legitimacy. Second, Mary engaged in self-censorship out of fear of eliciting a statement which might make her accountable for non-referral. As someone critical of the Prevent policy, Mary's withholding was a form of defensive medicine; her fear of professional liability took precedence over the welfare of her patient. Such self-surveillance is indicative of non-coercive systems of control (Pylypa, 1998). Third, this clinical encounter highlights the challenges in accounting for how the Prevent duty can transform clinical practice. The UK government relies primarily on referral statistics to convey the success of Prevent (Heath-Kelly, 2017b, p. 299). Mary's case outlines the limitations of such an approach. Prevent's observable impact on Mary's clinical practice appears negligible, but she did *refuse* a path of interrogation which she might have gone down otherwise. This invisible change—an incalculable disruption according to Prevent statistics—reveals the broader implications of how the race frame operates in healthcare.

Cindy

Cindy is a racialised minority, non-Muslim female psychiatrist who also consults a team of mental health staff at her NHS Trust. As a senior consultant psychiatrist, Cindy played an important role supervising a team of mental health staff. One of the patients in discussion was a girl, Joan. Joan was suffering from domestic abuse; a situation which proved difficult for the team, however they learned to manage under Cindy's guidance. During the course of treatment, Joan became romantically involved with a Muslim and subsequently converted to Islam. Though her conversion was already a subject of concern, the theme of

radicalisation appeared once Joan decided to wear the *hijab* (the headscarf). At that point, concerns with domestic abuse during Cindy's supervision took backseat to the threat of potential radicalisation. When Cindy questioned why radicalisation was suddenly so important, the room fell silent. The team was shocked Cindy did not acknowledge the gravity of potential radicalisation. Cindy admits it was difficult to watch her team prioritise the elusive threat of radicalisation to actual abuse. Cindy suspected Prevent was a racialised policy which disproportionately affected Muslims, and the sudden focus on the headscarf affirmed her suspicion. (first author, interview)

The headscarf in public consciousness is a political signifier which embodies the gendered element of the race frame, pertaining to female victimhood of a misogynistic cultural/religious regime. Indeed, emerging studies have found that Western healthcare staff perceive Muslim women donning the headscarf as cultural victims and brainwashed by patriarchy (Laird et al., 2007, p. 925). The fact that Joan was a convert complicates things even further: White conversion to Islam contests and destabilizes predefined political constructions of Britishness, which raises suspicions of radicalisation (Schuurman, Grol, & Flower, 2016).

Cindy provided further context to the team's sudden interest in radicalisation. She explained that her team had recently received Prevent training—they were primed for counter-radicalisation. Furthermore, Cindy mentioned that the increasing regulation of professional autonomy was a direct response to budget-cuts, whereby clinical efficiency was expected to be maintained with less resources. Thus, Cindy blamed austerity for allowing racialised policies such as Prevent to thrive in an environment of increasing managerial overregulation, providing staff with little capacity to question their novel roles⁴.

Hamza

Hamza, a racialised Muslim male psychiatrist, admitted agreeing with the *spirit* of Prevent; an auxiliary to the NHS where patients could be sent for ideological reprogramming. But Hamza's attitude towards Prevent changed with the introduction of a patient, Michael. Michael was a white male who shared an extraordinary disdain for the homeless. Hamza explained Michael had a series of aggressive encounters with homeless individuals in the past, in one instance leading to assault. Michael's resentment of the homeless indicated he might do so again in the future. For Hamza, Michael's aggression—not indicative of an imminent threat of violence, nor devoid of its potential—seemed like a perfect fit for Prevent, not least because the demonization of homelessness was clearly an ideological artifact associated with neoliberalism. Thus, it seemed Michael was in dire need of ideological reprogramming to prevent future violence. The NHS Trust's safeguarding lead immediately rejected the Prevent referral. Hamza was informed it did not fit under Prevent's purview. It dawned on Hamza that Prevent was not geared towards the prevention of violence; rather, it exclusively addressed the violence of *particular groups and ideologies*. (first author, interview)

Neoliberalism is an ideology oft associated with the increasing marginalisation of homelessness, as exemplified by the intensification of hostile architecture around major cities (Petty, 2016). Neoliberalism however is not an ideology favoured by Prevent, nor does the policy purport to tackle ideologies beyond those associated with political violence in public discourse—Muslims and White Supremacists⁵. The point is not to unpack which violence should be deemed 'terrorism', but rather to underline the safeguarding lead's *immediate* presumption that Michael's violence was not ideological. As Michael was white, his violence was arbitrarily disassociated from ideology and he was privileged from prejudicial associations with terrorism. Conversely, one could question how the result might have been different if Michael had been a racialised Muslim—this was Hamza's eventual train of thought. It is

not difficult to conceive how a racialised Muslim's violence towards strangers would be subject to more scrutiny (Ciftci, 2012). Indeed, white attackers are less likely to be designated terrorists than racialised Muslim attackers, which then impacts how terrorism statistics are collated (Corbin, 2017). This is precisely Mills' (2018) thesis on 'White innocence' in the UK's counter-terrorism strategy, which privileges Whiteness while normalising the racial order upon which the strategy was built.

I was informed of a number of white patients referred to Prevent throughout my fieldwork. Without exception, referrals always included some *explicit* mention of Far-Right groups or their associated white nationalist ideologies. For example, Adam, a racialised Muslim psychiatrist, questioned if a racialised White male patient had been referred to Prevent due to his consumption of English Defense League videos, to which his colleague replied in the affirmative. While such observations are far from generalizable, it does question what sort of *conclusive behaviours* white patients must exhibit to successfully warrant a Prevent referral.

5. Discussion: Performing colorblindness, reinforcing racist frames

Using Goffman's conceptualisation of frames, we argue the UK government employs multiple logics to convey the threat of radicalisation in order for it to 'make sense' to healthcare staff. The two frames it employs most readily are the psychological and ideological frames, whereby *vulnerable* individuals are presumed to be *susceptible* to radicalisation if exposed to *bad* ideologies. However, we also note that the race frame – the logic by which certain racialised Muslim bodies are more readily associated with radicalisation, whereby Whiteness is privileged – remains ubiquitous throughout.

Race thus was never absent in Prevent policy or training—it was omnipresent. In its omnipresence, the performance of colorblindness remained equally consistent. Prevent must *actively* address public consciousness and the race frame which views Muslims as the 'Other' to Whiteness. This colorblind performance may occur explicitly by reminding staff to not associate radicalisation with mosque

attendance, or implicitly by reminding staff that everyone is equally susceptible to radicalisation, just as everyone is susceptible to mental illness. The active recognition and negation of the race frame is precisely what we relate to as *performative colorblindness*. Contemporary concerns of institutional racism in the NHS lie not only with Prevent, but across various controversies such as the overrepresentation of Black people sectioned by police in psychiatric wards (UK Government, 2018); the hostile environment rendering NHS staff liable to verify the legal status of patients who *may* be undocumented (Dexter, 2017); and over one-third of Muslim women reporting experiences of bullying while wearing a headscarf in an operating theatre (Malik et al., 2019). We argue there are three reasons why the Prevent policy persists despite emerging concerns of institutional racism in the NHS.

One reason has to do with the myth of a post-racial society (Kalwant, 2018). This myth postulates that racism is no longer hegemonic—affecting all public bodies including the NHS—but a social pathology belonging exclusively to those on the political margins of society. As such, overt racism is disassociated from the racialised nationalism widespread in British society (Virdee and McGeever, 2018). Furthermore, the UK's departure from 'multiculturalism', followed by a push for sterner cultural integration by means of 'muscular liberalism', confounds the race frame with citizenship building. British Muslims are consistently under scrutiny for their integration of 'fundamental British Values' (Habib, 2017, p. 54). As a counter-example, Alexander (2012) provides a genealogy of how the American War on Drugs was built upon an institutionally racist framework criminalising Black bodies. Alexander argues that one of the ways it has been so difficult to address institutionally racist policies associated with American drug policing is their colorblindness in a presumed post-racial society. Because politicians frame *drug dealers* and *users* as disassociated from race, they cannot be held accountable for the mass incarceration of Black Americans. Like Prevent, the focus on *implementation* disassociates *policy* from its racism, placing the responsibility instead on staff to 'not be racist.'

Another way colorblind practices are sustained in healthcare can be related to the increasing psychologisation of social and political issues, localising them within individuals (Madsen and Brinkmann, 2011). As we have seen above, mental health professionals are increasingly adopting roles to tackle problems outside the traditional purview of psychology. Resilience is an emerging concept in this respect, whereby psychological risk and protective factors are mobilised for the sake citizenship-building and national security (Joseph, 2018, p. 68). Psychologisation and its veneer of scientific accuracy disguises how risk and vulnerabilities are necessarily normative, value-laden constructs that are subject to power. Thus, mental health professionals may not be cognizant how psychological practices operate in a political and racialised space. This is especially relevant to the subject of terrorism. When terrorism evolved as an object of study from counter-insurgency studies in the mid-20th century, one of its central changes had to do with rationality (Stampnitzky, 2013). Previously, counter-insurgents were seen as (morally deplorable) *rational* actors. The introduction of ‘terrorism’ re-framed political violence as *irrational*, erasing political agency and framing violence as a moral evil in-and-of-itself. Naturally, irrationality is by and large the purview of mental health. Thus, an individual’s cognitive distortions, rather than their political demands, became the locus of intervention. The mental health framework is especially lucrative in its colorblindness as it establishes a positivist attitude towards the human condition: just as everyone is susceptible to cognitive distortions, so too is everyone susceptible to radicalisation.

Finally, Prevent is able to sustain colorblindness in mental health because of its increasing determination to tackle the rising threat of the Far-Right (HM Government, 2018). As we saw with the case of Hamza however, White referrals to Prevent still operate upon a race frame in that *their bodies alone were insufficient to conjure the threat of radicalisation*. The disassociation of Michael’s aggression from ideology must be juxtaposed with the banal referrals of patients who don a headscarf. How does Prevent then operate towards racialised white individuals, and how will it address a populace wherein

large segments espouse ethnonationalist, xenophobic or Islamophobic beliefs? These questions are significant in the post-Brexit era, given that *one-third of Britons* believe Islam is a threat to the British way of life (Perraudin, 2019). There is a false equivalence drawn between Muslim and Far-Right ‘extremisms’, as Fekete (2018, p. 20) argues, whereby the Far-Right have moved “from the periphery to the centre of society, consolidating their authority at a local level, and establishing power bases in municipal and regional governments across Europe.” We cannot discard the significance of this political moment—including the normalisation of xenophobia piloted by the Brexit campaign—from Prevent’s operation. The threshold differential of *who and what* represents the ‘threat’ in public consciousness, compounded by the individual focus on Far-Right members as society’s xenophobic outliers, is integral in the colorblind performance of a racialised policy. White referrals to Prevent do not disprove the race frame—they maintain the colorblindness of a racialised policy.

Developments: Public Health and Beyond Prevent

As the security industry continues its expansion, we would like to address counter-radicalisation’s novel pivot towards public health. A public health approach to counter-radicalisation has gained some traction in the last year, with Public Health Wales (Bellis and Hardcastle, 2019) and academics advocating this solution (Bhui et al., 2012). This approach frames the whole population potentially at risk of radicalisation, largely within a psychologising framework of risk factors detailed earlier. Though the means by which public health can address terrorism is beyond the scope of this paper, our primary contention is that extremism and radicalisation are racially-loaded constructs which inevitably draw upon the race frame in public consciousness. It begs to question: will a public health approach reinforce a colorblind, psychologizing strategy to political violence and further stigmatise Muslims in a post-Brexit era? This question is important: a recent systemic review of counter-radicalisation found that the primary push factor towards political violence appears to be social deprivation and sense of injustice (Vergani et al., 2018).

The UK government's introduction of the Prevent statutory duty into healthcare was not evidence-based; it was a political decision to institutionalise a nationwide moral imperative to counter the elusive threat of terrorism. Discussions of policy-based evidence, rather than evidence-based policy, are not new (Gregg, 2010). As long as Prevent remains a statutory duty, we argue the race frame upon which it operates will worsen Muslim healthcare access and treatment—and training staff to 'not be racist' will prove insufficient. We thus contend that the Prevent statutory duty should be reconsidered, *not as a function of how successfully it achieves its objectives but in relation to the political climate in which the policy is embedded*. There are three essential components to this argument: 1) the threat of terrorism is hegemonically associated with racialised Muslims in public consciousness; 2) NHS counter-radicalisation will draw upon the race frame given healthcare settings reflect public consciousness; and 3) Prevent cannot resolve the race frame with colorblind training, by either dismissing or raising/erasing the potential of racialisation. Though we have corroborated each component above, prospective research may elucidate their relations further.

Criticism towards Prevent is often followed by a question: if not Prevent, how should society address political violence? The Transnational Institute (TNI) recently published an evidence-based report proposing a progressive alternative to the UK's counter-terrorism apparatus—including the Prevent policy—which addresses all *immediate* violence through established NHS safeguarding practices, *prospective* violence through social and political reforms, and white nationalism through progressive and historically-grounded anti-racist reforms (Blakeley et al., 2019). In doing so, the TNI provides an example of a viable alternative to political violence which appears to take the possibility of institutional racism seriously.

6. Conclusion

This paper provides an ethnographic account of how counter-radicalisation enters clinical settings. This does not mean that the Prevent policy is the *cause* of Islamophobia in the NHS. Associations of non-white bodies with threat will persist, even if the Prevent duty were to be abolished—the policy simply institutionalises this association within the auspices of intuition. We hypothesise that the Prevent policy, when operationalised, turns the healthcare setting from a place of healing to one which reproduces and amplifies racial tensions. Colorblindness may be well-intentioned, and we are convinced the majority of those we engaged in the Prevent strategy do so in good will. However, by ignoring the reality of the race frame associated with radicalisation, “‘good people’ with the notable goal of ignoring race actually do harm in interracial interactions” (Neville et al., 2016, p. 9). If equal rights and freedom of discrimination is important for the NHS, attention should focus less on raising awareness of Far-Right extremism, and more on addressing institutional racism in healthcare.

¹ It is important to affirm the primary author is a racialised Muslim. The implications of this are discussed elsewhere (Younis and Jadhav, 2019).

² Such participants affirmed the need for a counter-radicalisation strategy or celebrated its positive potential to address the Far-Right threat. While it is impossible to speculate the attitudes of NHS staff who may have withheld participation due to our critical positioning, an opinion piece by Hurlow et al. (2016) suggests they believe staff are equipped to tackle the threat of terrorism via the psy-disciplines. They also see criticisms towards Prevent as unreasonable expressions of political correctness towards Muslims.

³ If you check the mosque attendance box, you will be informed you are mistaken and returned to this screen to choose the ‘correct’ answers.

⁴ The structural conditions underlying Prevent’s operation in the NHS are discussed in Younis and Jadhav (2019) in more detail.

⁵ Prevent’s recent addition of anti-fracking and animal rights activists challenges the rigidity in the government’s understanding of political violence (Netpol, 2018).

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Appendix

Table 1. Participant Characteristics

Pseudonym	Profession	Gender	Location	Ethnicity	Religion
<i>Adam</i>	Psychiatrist	Male	Midlands	Ethnic Minority	Muslim
<i>Amy</i>	Psychiatrist	Female	South	Ethnic Minority	Non- Muslim
<i>Fatima</i>	Psychiatrist	Female	North	Ethnic Minority	Muslim
<i>Hafsa</i>	Psychiatrist	Female	South	Ethnic Minority	Muslim
<i>Harrison</i>	Psychiatrist	Male	South	White	Non- Muslim
<i>Jack</i>	Psychologist	Male	South	White	Non- Muslim
<i>Jessica</i>	Psychologist	Female	South	Ethnic Minority	Non- Muslim
<i>John</i>	Psychiatrist	Male	South	White	Non- Muslim
<i>Khalid</i>	Psychiatrist	Male	South	Ethnic Minority	Muslim

<i>Maryam</i>	GP	Female	North	Ethnic Minority	Muslim
<i>Michael</i>	Psychiatrist	Male	South	White	Non- Muslim
<i>Nadeem</i>	Manager	Male	South	Ethnic Minority	Muslim
<i>Neumann</i>	Psychiatrist	Male	South	White	Non- Muslim
<i>Sara</i>	Psychologist	Female	South	White	Non- Muslim
<i>Susan</i>	GP	Female	South	Ethnic Minority	Non- Muslim
<i>Waleed</i>	Psychiatrist	Male	North	Ethnic Minority	Muslim
<i>Yaqeen</i>	Psychiatrist	Male	South	Ethnic Minority	Muslim